STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155782	A. BUILDING 00 B. WING	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK HEALTH CAMPUS	814 S 6TH ST MONTICELLO, IN47960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: October 4, 5, 6, 7, 2011 Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410 Survey Team: Linda Campbell, RN, TC Christi Davidson, RN Courtney Hamilton, RN (October 4 & 5, 2011) Census Bed Type: SNF/NF: 7 SNF: 29 Residential: 34 Total: 70 Census Payor Type: Medicare: 21 Medicaid: 7 Other: 42 Total: 70 Sample: 10 Supplemental: 4 Residential Sample: 9 These deficiencies also reflect state	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 10/12/11 Cathy Emswiller RN			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to ensure care plans were updated related to interventions implemented to prevent falls for 2 of 10 residents with care plans in a sample of 10. (Residents #23 and #30). Findings include: 1. Resident #30's clinical record was reviewed on 10/5/11 at 9:15 A.M. The record indicated the resident had fallen on	F0279	Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:Care plans have been updated for Residents #23 and #30 to reflect interventions as related to falls. Identificaton of other reidentshaving the potential to be affected by the same alleged deficient practice and corrective action taken:All residents assessed at risk for falls or residents who have fallen have been identified as having the potential to be affected. Care plans have been reviewed and	11/06/2011

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	3/31/11, 4/1/11, 4/5/11, 4/24/11, 5/30/11, 6/6/11, 7/24/11, 9/6/11, and 9/24/11. A resident care plan dated 3/3/11 indicated "...Falls. At risk for injury...Interventions...Use fall risk assessment to identify risk factors...Report falls to MD/responsible party...Provide environmental adaptations:...Half rails as enabler...Call light within reach...Area free of clutter...Wheelchair...Educate/remind resident to request assistance prior to ambulation..." "Fall Circumstance Assessment and Intervention" forms indicated: 3/31/11 - the additional interventions recommended were to ensure the wheelchair brakes were locked and a pressure alarm was added to the wheelchair. The resident care plan had not been updated to include those interventions. 4/1/11 - the additional interventions recommended were to have frequently used items within reach and hook alarm to bottom of wheelchair. The resident care plan had not been updated to include those interventions. 4/5/11 - the additional intervention		updated to reflect interventions as related to falls. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:Each new admission is assessed for fall risk with appropriate intervention initiated for prevention. Following each fall the resident is assessed with interdisciplinary approach and itervention and care plan updated to reflect current interventions.How the corrcitve measures will be monitored to ensure the alleged deficient practice does not recur:DHS or designee is reviewing each new admission for fall risk assessment and appropriate intervention implemented as well as reviewing each resident's medical record following a fall for appropriate and current interventins and updated care plan. All monitoring results will be reproted each month to QA committee x 7 months for review and evaluation of effectiveness. All corrective actions will be completed by 11/6/11	

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	recommended was a trial of a wedge cushion in the wheelchair. The resident care plan had not been updated with that intervention. 4/24/11 - the additional interventions recommended were toilet every two hours, nonskid footwear, low bed, defined parameter mattress, motion detector, and mats to floor in room. The resident care plan had been updated with the low bed but none of the other additional interventions. 5/15/11 - the additional interventions recommended were dycem in wheelchair and a trial of a self release seatbelt. The resident care plan had not been updated to include those interventions. 5/30/11 - the additional interventions recommended were replace batteries in alarm and move the alarm box out of resident's reach. The resident care plan had not been updated to include those interventions. 6/6/11 - the additional interventions recommended were teach w/c safety, diversional activities, and hip protectors, and increase amount time with ambulation. The resident care plan had not been updated to include those interventions.			

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	9/24/11 - documentation on the resident care plan was lacking related to any additional interventions recommended after the fall. Interview on 10/5/11 at 10:15 A.M. with the Director of Nursing indicated the care plan had not been updated with interventions after falls and should have been updated. 2. The record for Resident #23 was reviewed on 10/05/11 at 12:45 p.m. Diagnoses included, but were not limited to hip joint replacement, persistent mental disorders due to condition, hypertension, anxiety, and senile dementia uncomplicated. The facility Assessment Review and Considerations dated 04/06/11 indicated, "...This resident has the following risk factors that may contribute to falls:...Medical condition/diagnosis...An individualized care plan has been initiated to address the above risk factors and minimize the risk of falling and/or reduce the likelihood of injury...." The admission Minimum Data Set (MDS) Assessment dated 04/13/11 indicated Resident #23 had severe vision			

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	impairment. The MDS indicated Resident #23 was not oriented to year or day of the week and recalled "blue" and "bed" with cueing. Resident #23's total cognitive score was a 7 out of a possible 15, indicating the resident was severely impaired in cognitive decision-making skills. The MDS indicated Resident #23 was an extensive assist with two person physical assist for transfer and toilet use. The MDS indicated the resident was not steady moving on and off the toilet and required human assistance to stabilize. A care plan titled, "Falls," dated 04/20/11 indicated, "At risk for fall/injury AEB [as evidenced by] History of Falls...Medication usage...pain...Resident will have reduced risk of fall related injury by utilizing precautions..._Use fall risk assessment to identify risk factors_Report falls to MD/responsible party_Monitor for side effects of any drug that can cause gait disturbance, orthostatic hypotension, weakness, sedation, vertigo, change in mental status...Report to MD any negative side effects associated with residents medication use_Provide environmental adaptations:...Half rails as enabler_Call light within reach...Provide/monitor use of adaptive devices:...Wheelchair...."			

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	A nurses note dated 04/28/11 at 7:05 p.m. indicated, "...writer observed res [resident] laying on the floor to [left] side beside toilet. CRCA [certified resident care aide] was present in the BR [bathroom] [sign for and] reported that she witnessed fall. CRCA stated that res was attempting to wipe self [sign for after] toileting, shifted weight on toilet riser, then fell to floor...Staff unable to move res...severe [sign for left] hip pain." A nurses note dated 04/28/11 at 7:50 p.m. indicated, "...en (sic) route to ...ER [emergency room]." A Fall Circumstance, Assessment and Intervention form dated 04/28/11 at 7:05 p.m. indicated resident fell in the bathroom, and CRCA was in the bathroom at the time of the fall. The fall risk re-assessment questions included, but were not limited to, "Resident has cognitive or memory impairment that effects safety and judgement?" This question marked "yes." "Resident has difficulty understanding and following directions?" This question marked "no." "Resident requires assistance to transfer?" This question marked "yes." "Resident is unable to maintain balance while sitting, standing or walking without assistance?" This question marked "yes." "Resident refuses to comply with safety measures			

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	such as call light use, alarms, appliances, etc?" This question marked "yes" with a written note that indicated, "often forgets." The prevention update indicated the toilet riser replaced. No IDT [interdisciplinary team] recommendations indicated. The fall care plan lacked documentation of an updated intervention to prevent falls. A nurses note dated 06/10/11 at 1220 [12:20 p.m.] indicated, "Res has been c/o [complain of] severe pain to [sign for right] knee since last evening...Res having difficulty bearing weight on that knee...." A nurses note dated 06/11/11 at 0500 [5:00 a.m.] indicated Resident #23 continues to have right knee pain. A nurses note dated 06/12/11 at 1800 [6:00 p.m.] indicated, "Ambulation difficult due to [sign for right] knee pain." A nurses note dated 06/13/11 at 0400 [4:00 a.m.] indicated, 'Res found on floor by CRCA states attempting to get up and slipped...." A Fall Circumstance, Assessment and Intervention form dated 06/13/11 at 0400 [4:00 a.m.] indicated Resident #23 fell in resident's room attempting to transfer self.			

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	The fall risk re-assessment questions included, but were not limited to, "Resident has cognitive or memory impairment that effects safety and judgement?" This question marked "no." "Resident has difficulty understanding and following directions?" This question marked "no." "Resident requires assistance to transfer?" This question marked "yes." "Resident is unable to maintain balance while sitting, standing or walking without assistance?" This question marked "no." "Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc?" This question marked "no." The prevention update indicated resident was educated on call light usage. No IDT [interdisciplinary team] recommendations indicated. The "Fall" care plan was updated on 06/13/11 and added "hipsters" as an intervention. An MDS dated 07/03/11 indicated resident #23 had severely impaired vision. The MDS indicated Resident #23 did not recall the correct year, and recalled "blue" and "bed" with cueing. The total cognitive score was an 8 out of a possible 15, indicating the resident was moderately impaired in cognitive decision-making skills. The MDS indicated the resident			

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	was a one person physical assist to transfer and toilet. The MDS indicated Resident #23 was not steady and needed human assistance to stabilize to do activities such as moving on and off toilet. A nurses note dated 09/19/11 at 0900 [9:00 a.m.] indicated, "...CRCA...found res laying on her back on the bathroom floor. Res stated, 'I forgot to get my walker and walked in here without it...res very tearful...tailbone pain...Res bed was wet as well as her hipsters were lying on bed wet. When asked if she took them off res stated, 'yes, I had to they are wet.'...report called to...hospital ER." A nurses note dated 09/19/11 at 1140 [11:40 a.m.] indicated, "Res returned from hospital...[sign for no] new orders...." A Fall Circumstance Investigation dated 09/19/11 at 0900 [9:00 a.m.] indicated, "...Res transferred self and ambulated to bathroom [sign for without] walker by self...." The fall risk re-assessment questions included, but were not limited to, "Resident has cognitive or memory impairment that effects safety and judgement?" This question marked "yes." "Resident has difficulty understanding and following directions?" This question marked "no." "Resident requires assistance to transfer?" This question			

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	marked "no." "Resident is unable to maintain balance while sitting, standing or walking without assistance?" This question marked "no." "Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc?" This question marked "yes." The prevention update indicated, "...teach w/c [wheelchair] safety...education on importance of w/c and walker use...." No IDT recommendations indicated. The "Fall" care plan update on 09/19/11 indicated, "...education on Res using walker." On 10/06/11 at 10:55 a.m. Resident #23 was observed laying on her bed with her eyes closed. The resident's wheelchair was positioned at the foot of the resident's bed. During an interview on 10/06/11 at 10:56 a.m., Certified Resident Care Aide (CRCA) #2, indicated Resident #23 transferred self from bed to wheel chair and to the toilet. CRCA #2 indicated the resident called for assistance if the resident's brief needed changed, otherwise does not call for assistance. CRCA #2 indicated the resident has poor vision and "can't see her watch." During an interview on 10/06/11 at 10:57			

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	a.m., LPN #3 indicated Resident #23 was listed as an assist of 1 on the daily assignment sheet under mobility. On 10/06/11 at 12:40 p.m., the Executive Director provided the daily assignment sheet for Resident #23 for 10/06/11. The daily assignment sheet dated 10/06/11 at 11:55 a.m. indicated resident #23 was an assist of 1 for mobility. During an interview on 10/06/11 at 1:40 p.m., the Director of Health Services (DHS) indicated she assisted the CRCA on 04/28/11 to put Resident #23 on the toilet. She indicated the toilet riser was loose. She indicated documentation does not always reflect when two person transfers or assists are used. DHS indicated the intervention was to replace the riser and bolt it down. She indicated the intervention was not reflected on the care plan because it was environmental. DHS indicated Resident #23 was taking self to bathroom. DHS indicated, "She has come a long way." DHS indicated staff gives resident reminders and encouragement to use walker and call light. A policy provided by the DHS on 10/05/11 at 1:10 p.m. titled, "Fall/Safety Management Educational Information,"			

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	indicated, "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...the 'Fall Circumstance and Reassessment Form'..includes the inveswtigation (sic) of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT [interdisciplinary team] to evaluate thoroughness of the investigation and appropriateness of the interventions...It is imperative to discover, 'what the resident was trying to do at the time of the fall.'...If an intervention has been tried, but falls still occur, move on to another intervention as prior one has not been effective. Continuing current plan=expect same results Change plan=expect different results...Interventions should be initiated at the time a 'risk' is identified, not just after a fall occurs...." The policy included multiple interventions for least restrictive, moderately restrictive and highest restrictive. 3.1-35(a)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement interventions to prevent falls for 2 of 6 residents with falls in a sample of 10. (Residents #23 and #30). Findings include: 1. On 10/4/11 at 8:00 A.M., with the Director of Nursing, Resident #30 was identified as having had several falls. The last fall was "last week." The resident was identified as having a bed and chair alarm in place. On 10/5/11 at 9:15 A.M., Resident #30 was observed lying in bed in her room. The bed was in low position. The alarm box was hanging on the side rail next to the resident's head. The wheelchair was by the door. There were no mats on the floor. There was no motion sensor in the room. There was no dycem in her wheelchair. Interview on 10/5/11 at 10:00 A.M. with the Director of Nursing indicated the resident had two alarms on the bed. Observation at the time of the interview indicated there was only one alarm being	F0323	Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:Interventions have been implemented to prevnet falls following completion of risk assessment for Resident #23 and #30Identification of other residents having t potential to be affected by the same alleged deficient practice and corrective actions taken:All residents assessed at risk for falls or residents who have fallen have been identified as having the potential to be affected. Interventions have been implemented to prevent falls following completion of risk assessements. Measures put into place and systemic change made to ensure the alleged deficient practice does not recur:Each new admission is assessed for fall risk with approproate itervention intitiated for prevention. Following each fall the resident is assessed with interdisciplinary approach and intervention and care plan updated to reflect current interventions. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur:DHS or designee is reviewing each new admission for fall risk assessment and	11/06/2011

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	used on the bed. Resident #30's clinical record was reviewed on 10/5/11 at 9:15 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, cerebrovascular accident (stroke), weakness, and dementia. A Minimum Data Set (MDS) Quarterly Assessment dated 8/12/11 indicated the resident was moderately impaired in cognitive decision-making skills, required extensive one-person physical assistance for transfer and toilet use, required limited one-person physical assistance for ambulation, was not steady and only able to stabilize with human assistance for balance, and had fallen. A "Physical Therapy Initial Plan of Care" dated 2/14/11 indicated "...has demonstrated a significant decline in functional transfers, mobility, and self care tasks...Gait...Assistance: Mod A (moderate assistance) to Max A (maximum assistance)...Transfers...Bed <-> (to and from) Chair: Mod A...Wheelchair <-> Commode: Mod A...Balance...Static Standing: Fair...Dynamic Standing: Fair-...Fall risk...High...Safety Awareness...Poor..." A resident care plan dated 3/3/11		approproate interventon implemented as well as reviewing each resident's medical record following a fall for appropriate and current interventions and updated care plan. All monitoring results will be reported each month to QA committee x 7 months for review and evaluation of effectiveness. All corrective actions will be completed by 11/6/11.	

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	155782	A. BUILDING 00 B. WING	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK HEALTH CAMPUS	814 S 6TH ST MONTICELLO, IN47960

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	indicated "...Falls. At risk for fall/injury AEB (as evidenced by) History of falls (indicated by checkmark)...Interventions...Half rails as enabler...Call light within reach...Area free of clutter...Wheelchair...Education/remind resident to request assistance prior to ambulation...bed et (and) w/c (wheelchair) alarm...High/low (indicated by arrows) bed..." A "Monthly Nursing Assessment & Data Collection" form dated 4/22/11 indicated "...Safety...History of falls? Y (Yes-circled)...Requires assistive devices and/or forgets to use? Y (circled)...Non-compliant with safety measures? Y (circled)...Can remove safety devices or doesn't prevent from previous act? Y (circled)...Fall Risk..Continue to monitor for impact of risk and care plan as appropriate...Res often attempts to self transfer..." A nurses' notes dated 3/31/11 at 6:30 P.M. indicated "Res (resident) was self ambulating from W/C to standing. CRCA (Certified Resident Care Aide) heard alarm & observed Res sitting on buttocks c (with) bilat (bilateral) legs flexed to (rt) (right) side...Alarms on & functioning . Nonskid shoes on. W/C brakes not locked..."			

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	A "Fall Circumstance Assessment and Intervention" form dated 3/31/11 at 6:30 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Transferring self (indicated by X)...Family pushed Res into Rm (room) & Res had alarm on...Toileting needs...Safety equipment in place and functioning at time of incident? N (circled)...Wheelchair brakes locked? N (circled)...Prevention Update...Call bell... Ensure w/c brakes are locked...Bed and/or chair alarm...Had chair pressure alarm & tabs alarm applied..." Documentation indicated IDT (interdisciplinary team) review was done on 4/1/11. There were no additional recommendations after the 3/31/11 fall. A resident care plan dated 3/3/11 was not updated to indicate keeping the wheelchair brakes locked and the application of a pressure alarm after the 3/31/11 fall. A nurses' note dated 4/1/11 at 6:00 P.M. indicated "...Res was self transferring self from w/c to bed c (with) nonskid shoes. Res took alarm off w/c & disconnected it. CRCA observed on floor..." A "Fall Circumstance Assessment and Intervention" form dated 4/1/11 at 4:00			

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	P.M. indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Transferring self (indicated by X)...Safety equipment in place and functioning at time of incident? N (circled). Res took alarm off...Wheelchair brakes locked? N (circled)...Prevention Update...Frequently used items within reach...Orient to environment...Call bell... Ensure w/c brakes are locked...Bed and/or chair alarm...Alarm hooked to bottom of w/c..." Documentation indicated no date for the IDT (interdisciplinary team) review. There were no additional recommendations after the 4/1/11 fall. A resident care plan dated 3/3/11 was not updated to indicate to keeping frequently used items within reach and placing the alarm on the bottom of the wheelchair after the 4/1/11 fall. A nurses' note dated 4/5/11 at 6:50 P.M. " Resident observed on floor beside w/c & bed. CRCA heard w/c alarm & went to assist...w/c brakes not locked..." A "Fall Circumstance Assessment and Intervention" form dated 4/5/11 at 6:35 P.M. at indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Transferring self (indicated by X)...Toileting needs (indicated by X)...Safety equipment in place and			

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	functioning at time of incident? Y (Yes) (circled). ...Wheelchair brakes locked? Y (circled)...Prevention Update...Therapy Evaluation...Call bell...chair alarm (circled)...Wedge cushion trial..." Documentation indicated IDT (interdisciplinary team) review was done on 4/6/11. There were no additional recommendations after the 4/6/11 fall. A resident care plan dated 3/3/11 was not updated to indicate the use of a wedge cushion after the 4/5/11 fall. An undated entry indicated "Sensor alarm by bed..." A "Fall Circumstance Assessment and Intervention" form dated 4/24/11 at 10:45 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Toileting (indicated by X)...Toileting needs (indicated by X)...Safety equipment in place and functioning at time of incident? Y (circled)...Res able to turn off motion sensor...Prevention Update...Toilet q2h (every two hours)...Nonskid footwear...Low bed...Defined parameter mattress...bed and/or chair alarm...Bed in low position...Motion detector..Mats to floor in room...Brought to nurses station..." Documentation indicated the IDT (interdisciplinary team) review was done on 4/25/11. Documentation indicated "IDT review of above			

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	prevention update agrees as appropriate to maximize safety...Y (circled)..." A resident care plan dated 3/3/11 was not updated to indicate the resident should be toileted every two hours, the use of a defined parameter mattress, or mats on the floor after the 4/24/11 fall. A nurses' note dated 5/15/11 at 7:20 A.M. indicated "CRCA summoned writer to (room number) where res was observed sitting on buttocks on floor by bedside in front of w/c. W/C pad alarm was sounding which had alerted staff of res (I) (independent) transfer et (and) fall. Res stated 'I was trying to get into bed.'...Res has dx (diagnosis): dementia et lacks safety awareness. Res failed to ask staff for assistance..." A "Fall Circumstance Assessment and Intervention" form dated 5/15/11 at 7:20 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor. W/c alarm sounded...Activity at time of fall:..Transferring self (indicated by X)...Res stated 'I was trying to get into bed'...Safety equipment in place and functioning at time of incident? Y (Yes) (circled). ...Wheelchair brakes locked? N (circled)...Prevention Update...Bed and/or chair alarm...dicem (sic) replace in w/c....will trial self release seatbelt..."			

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	Documentation indicated the IDT (interdisciplinary team) review was done on 5/16/11. Documentation indicated "IDT review of above prevention update agrees as appropriate to maximize safety...Y (circled)..." A resident care plan dated 3/3/11 was not updated to indicate the use of dicem (sic) in the wheelchair or the use of a self release seatbelt after the 5/15/11 fall. A nurses' note dated 5/30/11 at 6:45 P.M. indicated "...CRCA informed writer Res was noted being on floor beside bed. Res was attempting to transfer out of bed into w/c...Call light w/t (within) reach & not turned on...Bed alarm on but disconnected..." A "Fall Circumstance Assessment and Intervention" form dated 5/30/11 at 7:00 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Transferring self (indicated by X)...Improper or ill fitting footwear (indicated by X)...Safety equipment in place and functioning at time of incident? Y (Yes) (circled)...Res was in bed & took batteries our of alarm...Prevention Update...Call bell...Bed and/or chair alarm...Batteries replaced & box moved..." Documentation indicated the IDT (interdisciplinary team) review was			

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	done on 6/1/11. Documentation indicated "IDT review of above prevention update agrees as appropriate to maximize safety...Y (circled)..." A resident care plan dated 3/3/11 was not updated to indicate ensuring batteries were in the alarm box and moving the alarm box after the 5/30/11 fall. A "Monthly Nursing Assessment & Data Collection" form dated 6/6/11 indicated "Cognition...ST (short term) memory deficits/unable to recall after 5 minutes...Safety...Alarming velcro belt...History of falls? Y (Yes-circled)...Requires assistive devices and/or forgets to use? Y (circled)...Non-compliant with safety measures? Y (circled)...Can remove safety devices or doesn't prevent from previous act? Y (circled)...Fall Risk..An individualized care plan has been initiated to minimize the risk of falling and/or reduce the likelihood of injury...Continue current plan..." A "Fall Circumstance Assessment and Intervention" form dated 6/6/11 at 4:15 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Transferring self (indicated by X)...Safety equipment in place and functioning at time of incident? Y (Yes)			

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	(circled)...Wheelchair brakes locked? N (circled)...Prevention Update...Nonskid footwear...Call bell...Teach w/c safety...Ensure w/c brakes are locked...Diversional activities...Hip protectors..." Documentation indicated the IDT (interdisciplinary team) review was done on 6/7/11. Documentation indicated "IDT review of above prevention update agrees as appropriate to maximize safety...Y (circled)...Increase amount of time c (with) ambulation & re-eval (re-evaluate) in 2 weeks..." A resident care plan dated 3/3/11 was not updated to indicate to ensure the wheelchair brakes were locked, the use of diversional activities, and the use of hip protectors after the 6/6/11 fall. A nurses' note dated 7/24/11 at 8:15 P.M. indicated "Resident found on floor beside bed in (room number). PJ (pajama) bottoms, hipsters, and brief pulled down to knees. Resident states '...wanted to go to bathroom.'..." Documentation was lacking related to alarms being in place and functioning. A "Fall Circumstance Assessment and Intervention" form dated 7/24/11 at 8:15 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor...Activity at time of fall:..Toileting (indicated by			

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	slash). Wanted to go to bathroom...Alarm off resident, pj bottoms pulled down to (indicated by arrow) knee along with hipsters...Safety equipment in place and functioning at time of incident? N (circled)...Prevention Update...Bed and/or chair alarm...Bed in low position...Place in recliner @ nurses station..." Documentation indicated the IDT (interdisciplinary team) review was done on 7/25/11. Documentation indicated "IDT review of above prevention update agrees as appropriate to maximize safety...Y (circled)...Placing in recliner @ nurses station..." A resident care plan dated 3/3/11 and updated on 7/26/11 indicated "...in recliner after meals..." Nurses' notes indicated: 9/6/11 at 10:30 A.M. "Res transferring s (without) assist from w/c to bed. Alarm sounding off. Res was loosing (sic) balance so this nurse put her hands under res arms to keep her from falling then was assisted to bed c (with) ii (two) assist..." 9/6/11 at 5:00 P.M. "Resident's alarm (w/c) was sounding & CRCA went to assist & observed resident on the floor beside bed. Res had been trying to self transfer from w/c to bed. W/C alarm on &			

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	sounding...Res stated 'I was going to bed.'..." A "Fall Circumstance Assessment and Intervention" form dated 9/6/11 at 3:45 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor. Yes...Activity at time of fall:..Transferring self (indicated by X)...Safety equipment in place and functioning at time of incident? Y (circled)...Wheelchair brakes locked? N (circled)...Transferring self to bed...Prevention Update...Nonskid footwear...Call bell...Teach w/c safety...Alarming seat belt...Ensure w/c brakes are locked...Bed and/or chair alarm...Diversional activities...Dicem (sic) added to w/c..." Documentation indicated the IDT (interdisciplinary team) review was done on 9/7/11. Documentation indicated "IDT review of above prevention update agrees as appropriate to maximize safety...Y (circled)..." A resident care plan dated 3/3/11 and updated 9/7/11 indicated "dycem to w/c...w/c out of reach..." A nurses' note dated 9/24/11 at 4:30 P.M. indicated "Resident observed on floor in Rm (room) on buttocks c (with) back against hallway door. 0 (no) nonskid shoes...w/c was beside bed c (with) brakes on. Alarm (bed) sounding but was			

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	muffled by pillow..." A "Fall Circumstance Assessment and Intervention" form dated 9/24/11 at 4:30 P.M. indicated "...Witnessed: N (no) (circled)...Found on floor. Yes...Activity at time of fall:...Ambulating (indicated by X)...Improper or ill fitting footwear (indicated by X)...Safety equipment in place and functioning at time of incident? Y (circled)...Wheelchair brakes locked? Y (circled)...Bed alarm on & sounding. Resident had pillow on top of alarm...Prevention Update...Nonskid footwear...Call bell...Bed and/or chair alarm..." Documentation indicated the IDT (interdisciplinary team) review was done on 9/26/11. Documentation was lacking to indicate additional recommendations after the 9/24/11 fall. A resident care plan dated 3/3/11 indicated documentation was lacking related to any additional interventions being implemented after the 9/24/11 fall. Review on 10/6/11 at 12:40 P.M. of a CNA assignment sheet provided by the Administrator indicated "...Safety Risk F (falls)...Alaerm (sic) box to bed at foot of bed out of res reach...w/c out of res reach..." Interview on 10/5/11 at 10:15 A.M. with			

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	the Director of Nursing indicated the intervention of wedge cushion was not appropriate for the 4/5/11 fall circumstance. She indicated the fall was caused by the wheelchair brakes not being locked. She indicated the self releasing belt "did not work. It was just a trial." She was unsure when the motion sensor had been placed in room and the alarm box should be placed out of reach of the resident. She indicated there should have been two alarm boxes in the resident's room. She indicated there was no documentation of increased ambulation or the use of diversional activities after the 5/30/11 fall. She indicated the resident was alert and told staff when she needed the toilet so "toileting program was not needed." She indicated "we aren't really sure what is happening to the dycem. It wasn't in her wheelchair. It keeps disappearing. She still walks to dine although it isn't working." She indicated there were no additional interventions implemented after the 9/24/11 fall.			

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	2. The record for Resident #23 was reviewed on 10/05/11 at 12:45 p.m. Diagnoses included, but were not limited to hip joint replacement, persistent mental disorders due to condition, hypertension, anxiety, and senile dementia uncomplicated. The facility Assessment Review and Considerations dated 04/06/11 indicated, "...This resident has the following risk factors that may contribute to falls:...Medical condition/diagnosis...An individualized care plan has been initiated to address the above risk factors and minimize the risk of falling and/or reduce the likelihood of injury...." The admission Minimum Data Set (MDS) Assessment dated 04/13/11 indicated Resident #23 had severe vision impairment. The MDS indicated Resident #23 was not oriented to year or day of the week and recalled "blue" and "bed" with cueing. Resident #23's total cognitive score was a 7 out of a possible 15, indicating the resident was severely impaired in cognitive decision-making skills. The MDS indicated Resident #23 was an extensive assist with two person physical assist for transfer and toilet use. The MDS indicated the resident was not	F0323	Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:Interventions have been implemented to prevnet falls following completion of risk assessment for Resident #23 and #30Identification of other residents having t potential to be affected by the same alleged deficient practice and corrective actions taken:All residents assessed at risk for falls or residents who have fallen have been identified as having the potential to be affected. Interventions have been implemented to prevent falls following completion of risk assessements. Measures put into place and systemic change made to ensure the alleged deficient practice does not recur:Each new admission is assessed for fall risk with approproate itervention intitiated for prevention. Following each fall the resident is assessed with interdisciplinary approach and intervention and care plan updated to reflect current interventions. How the corrective actions will be monitored to ensure the alleged deficient practice does not recur:DHS or designee is reviewing each new admission for fall risk assessment and approproate interventon implemented as well as reviewing each resident's medical record following a fall for appropriate and current interventions and updated	11/06/2011

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	steady moving on and off the toilet and required human assistance to stabilize. A care plan titled, "Falls," dated 04/20/11 indicated, "At risk for fall/injury AEB [as evidenced by] History of Falls...Medication usage...pain...Resident will have reduced risk of fall related injury by utilizing precautions..._Use fall risk assessment to identify risk factors_Report falls to MD/responsible party_Monitor for side effects of any drug that can cause gait disturbance, orthostatic hypotension, weakness, sedation, vertigo, change in mental status...Report to MD any negative side effects associated with residents medication use_Provide environmental adaptations:...Half rails as enabler_Call light within reach...Provide/monitor use of adaptive devices:...Wheelchair...." A care plan titled, "ADL [activities of daily living] Self Care Deficit dated 04/20/11 indicated, "...Needs assistance or is dependent...Toilet Use...." A care plan titled, "Impaired cognitive skills," dated 07/05/11 indicated Resident #23 had memory problems and recall problems related to a diagnosis of dementia. Interventions included, but were not limited to assess changes in cognitive status and conduct regular safety		care plan. All monitoring results will be reported each month to QA committee x 7 months for review and evaluation of effectiveness. All corrective actions will be completed by 11/6/11.	

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	checks. A care plan titled, "Impaired vision," dated 07/05/11 indicated, '...Legally blind...Disease process (list):...Macular degeneration...." A Physical Therapy Progress Report dated for Period From 04/22/11 to 04/29/11 indicated, "...Skilled PT [physical therapy] is necessary to address balance and safely in ambulation to reduce risk for falls." A Skilled Nursing Assessment and Data Collection dated 04/23/11 indicated, "...ST [short term] memory deficits - unable to recall after 5 minutes...." A Skilled Nursing Assessment and Data Collection dated 04/28/11 indicated, "Cognitive patterns...remains the same...." A nurses note dated 04/28/11 at 7:05 p.m. indicated, "...writer observed res [resident] laying on the floor to [left] side beside toilet. CRCA [certified resident care aide] was present in the BR [bathroom] [sign for and] reported that she witnessed fall. CRCA stated that res was attempting to wipe self [sign for after] toileting, shifted weight on toilet riser, then fell to floor...Staff unable to move res...severe [sign for left] hip pain."			

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	A nurses note dated 04/28/11 at 7:50 p.m. indicated, "...en (sic) route to ...ER [emergency room]." A Fall Circumstance, Assessment and Intervention form dated 04/28/11 at 7:05 p.m. indicated resident fell in the bathroom, and CRCA was in the bathroom at the time of the fall. The fall risk re-assessment questions included, but were not limited to, "Resident has cognitive or memory impairment that effects safety and judgement?" This question marked "yes." "Resident has difficulty understanding and following directions?" This question marked "no." "Resident requires assistance to transfer?" This question marked "yes." "Resident is unable to maintain balance while sitting, standing or walking without assistance?" This question marked "yes." "Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc?" This question marked "yes" with a written note that indicated, "often forgets." The prevention update indicated the toilet riser replaced. No IDT [interdisciplinary team] recommendations indicated. The fall care plan lacked documentation of an updated intervention to prevent falls.			

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	A hospital discharge instruction sheet dated 04/28/11 indicated Resident #23 had a left hip contusion. A nurses note dated 06/10/11 at 1220 [12:20 p.m.] indicated, "Res has been c/o [complain of] severe pain to [sign for right] knee since last evening...Res having difficulty bearing weight on that knee...." A nurses note dated 06/11/11 at 0500 [5:00 a.m.] indicated Resident #23 continues to have right knee pain. A nurses note dated 06/12/11 at 1800 [6:00 p.m.] indicated, "Ambulation difficult due to [sign for right] knee pain." A nurses note dated 06/13/11 at 0400 [4:00 a.m.] indicated, 'Res found on floor by CRCA states attempting to get up and slipped...." A Fall Circumstance, Assessment and Intervention form dated 06/13/11 at 0400 [4:00 a.m.] indicated Resident #23 fell in resident's room attempting to transfer self. The fall risk re-assessment questions included, but were not limited to, "Resident has cognitive or memory impairment that effects safety and judgement?" This question marked "no." "Resident has difficulty understanding and following directions?" This question			

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	marked "no." "Resident requires assistance to transfer?" This question marked "yes." "Resident is unable to maintain balance while sitting, standing or walking without assistance?" This question marked "no." "Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc?" This question marked "no." The prevention update indicated resident was educated on call light usage. No IDT [interdisciplinary team] recommendations indicated. The "Fall" care plan was updated on 06/13/11 and added "hipsters" as an intervention. A nurses note dated 06/13/11 at 1830 [6:30 p.m.] indicated, "Fall review res has had sore knee pain...Res is SBA [stand by assist] for amb [ambulation] [sign for and] res states 'I just slipped off bed.' Educated res on using call light...." An MDS dated 07/03/11 indicated resident #23 had severely impaired vision. The MDS indicated Resident #23 did not recall the correct year, and recalled "blue" and "bed" with cueing. The total cognitive score was an 8 out of a possible 15, indicating the resident was moderately impaired in cognitive decision-making skills. The MDS indicated the resident			

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	was a one person physical assist to transfer and toilet. The MDS indicated Resident #23 was not steady and needed human assistance to stabilize to do activities such as moving on and off toilet. A Physical Therapy Discharge Summary dated 07/05/11 indicated Resident #23's current level of functioning was independent with transfers with a moderate fall risk. The discharge summary indicated the resident was oriented with confusion. A nurses note dated 07/19/11 at 0940 [9:40 a.m.] indicated, "Res very confused...stated 'the secret service are out to get us' ...order for UA [urinalysis] ...." A nurses note dated 08/03/11 at 3:15 p.m. indicated a medication had been discontinued per the doctor due to the resolution of the diagnosis for the medicine and possible side effects. A Monthly Nursing Assessment & Data Collection form dated 08/05/11 indicated resident was independent with toileting. The form indicated Resident #23 was "legally blind." The form indicated the resident had cognitive impairment that affects safety and judgement, and the resident was non-compliant with safety measures. The form indicated the resident			

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	required assistance to ambulate and transfer. A nurses note dated 09/19/11 at 0900 [9:00 a.m.] indicated, "...CRCA...found res laying on her back on the bathroom floor. Res stated, 'I forgot to get my walker and walked in here without it...res very tearful...tailbone pain...Res bed was wet as well as her hipsters were lying on bed wet. When asked if she took them off res stated, 'yes, I had to they are wet.'...report called to...hospital ER." A nurses note dated 09/19/11 at 1140 [11:40 a.m.] indicated, "Res returned from hospital...[sign for no] new orders...." A Fall Circumstance Investigation dated 09/19/11 at 0900 [9:00 a.m.] indicated, "...Res transferred self and ambulated to bathroom [sign for without] walker by self...." The fall risk re-assessment questions included, but were not limited to, "Resident has cognitive or memory impairment that effects safety and judgement?" This question marked "yes." "Resident has difficulty understanding and following directions?" This question marked "no." "Resident requires assistance to transfer?" This question marked "no." "Resident is unable to maintain balance while sitting, standing or walking without assistance?" This			

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	question marked "no." "Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc?" This question marked "yes." The prevention update indicated, "...teach w/c [wheelchair] safety...education on importance of w/c and walker use...." No IDT recommendations indicated. The "Fall" care plan update on 09/19/11 indicated, "...education on Res using walker." On 10/06/11 at 10:55 a.m. Resident #23 was observed laying on her bed with her eyes closed. The resident's wheelchair was positioned at the foot of the resident's bed. During an interview on 10/06/11 at 10:56 a.m., Certified Resident Care Aide (CRCA) #2, indicated Resident #23 transferred self from bed to wheel chair and to the toilet. CRCA #2 indicated the resident called for assistance if the resident's brief needed changed, otherwise does not call for assistance. CRCA #2 indicated the resident has poor vision and "can't see her watch." During an interview on 10/06/11 at 10:57 a.m., LPN #3 indicated Resident #23 was listed as an assist of 1 on the daily assignment sheet under mobility.			

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	On 10/06/11 at 12:40 p.m., the Executive Director provided the daily assignment sheet for Resident #23 for 10/06/11. The daily assignment sheet dated 10/06/11 at 11:55 a.m. indicated resident #23 was an assist of 1 for mobility. During an interview on 10/06/11 at 1:40 p.m., the Director of Health Services (DHS) indicated she assisted the CRCA on 04/28/11 to put Resident #23 on the toilet. She indicated the toilet riser was loose. She indicated documentation does not always reflect when two person transfers or assists are used. DHS indicated the intervention was to replace the riser and bolt it down. She indicated the intervention was not reflected on the care plan because it was environmental. DHS indicated Resident #23 was taking self to bathroom. DHS indicated, "She has come a long way." DHS indicated staff gives resident reminders and encouragement to use walker and call light. A policy provided by the DHS on 10/05/11 at 1:10 p.m. titled, "Fall/Safety Management Educational Information," indicated, "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative			

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	measures...the 'Fall Circumstance and Reassessment Form'..includes the inveswtigation (sic) of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT [interdisciplinary team] to evaluate thoroughness of the investigation and appropriateness of the interventions...Nurse caring for a resident at the time of a fall will initiate investigation into cause of the fall. It is imperative to discover, 'what the resident was trying to do at the time of the fall.'...If an intervention has been tried, but falls still occur, move on to another intervention as prior one has not been effective...Interventions should be initiated at the time a 'risk' is identified, not just after a fall occurs...." The policy included multiple interventions for least restrictive, moderately restrictive and highest restrictive. 3.1-45(a)(2)			

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review the facility failed to ensure interventions were implemented to prevent weight loss related to supplements for 1 of 3 residents with weight loss in a sample of 10. (Resident #3). Findings include: On 10/4/11 at 7:15 A.M., with the Director of Nursing, indicated the resident had had a weight loss since admission, had pressure ulcers which had healed, and was in contact isolation for clostridium	F0325	Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:Interventions to help ensure that Resident #3 maintains acceptable parameters of nutritional status have been reviewed an implemented per dietitian recommendations, physician orders and resident preferences related to supplements. Identification of other resdents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All residents assessed with the	11/06/2011

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	difficile (a bacteria). On 10/4/11 at 1:50 P.M. Resident #3 was observed lying in his bed with the head of the bed elevated. There was an overbed table across the bed. The resident's tray was on the overbed table and the resident was eating his lunch. There was a glass of red liquid on the tray, identified by the resident as "his juice." There was no pudding on the tray. Interview with the resident at the time of the above observation indicated "I get my shakes two times a day." On 10/5/11 at 9:05 A.M., with LPN #1, Resident #3 was observed sitting in his bed with an overbed table over the bed. The resident was eating his breakfast. There was a pink liquid in a plastic container on his tray. The pink liquid was identified by LPN #1 as "mighty shake." There was no pudding on the tray. LPN #1 indicated the resident should have had fortified pudding on his tray. She indicated "dietary didn't put it on. CNAs do." On 10/5/11 at 10:30 A.M., Resident #3 was weighed by the Director of Nursing. The resident's weight was 109.8 pounds. Resident #3's clinical record was reviewed		potential to be at risk for maintaining acceptable parameters ofnutritional status have the potential to be affected related to supplements. These residents have been reviewed and interventions implemented per dietitian recommendations, physician orders and resident preferences as appropriate. Measures put into place and systemic changes made to ensure the alleged deficient pracitce does not recur:Supplement orders have been placed on Medication Administration Record to ensure supplents are administered per physician order as well as percentage of intake of each supplement. CNA's will no longer provide fortified pudding to residents. Dining services will be responsible for serving fortified pudding with meals and licensed nurses will document percentage of pudding eaten by residnet on MAR. If pudding is ordered between meals licensed nurses will ensure resident receives the pudding and document percentage eaten. How the corrective measures will be monitored to ensure the alleged deficient pracitce does not recur:DHS or designee will review the Medication Administration Record a minimum of 3x weekly x 4 weeks for accurate documentatoin of supplement administration and intake. Then weekly x 7 months thereafter. All	

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	on 10/4/11 at 1:00 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, anemia, protein calorie malnutrition, and thrombocytopenia (low platelet count). The record indicated the resident had fallen at home and had laid on the floor for two days resulting in multiple pressure ulcers on back and coccyx. A Minimum Data Set (MDS) Admission Assessment dated 9/5/11 indicated the resident was cognitively intact, required limited one-person physical assistance for eating, had an admission weight of 118 pounds, and had no weight loss. A resident care plan dated 9/1/11 indicated "...Resident at nutrition risk AEB (as evidenced by)...multiple wounds on sacrum,coccyx, and back...Interventions...Monitor and report to the physician...Significant weight loss (indicated by checkmark)...Administer nutritional support as ordered...Vitamin supplement (indicated by checkmark), Supplements (indicated by checkmark)...Snacks offer TID (three times a day) (indicated by checkmark)...Offer substitutes if 50% or less is consumed (indicated by checkmark)..."		monitoring results will be reported each month to QA committee for review and evaluation of effectiveness. All corrective actions will be compeleted by 11/6/11.	

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	A physician's orders recapitulation dated October 2011 indicated "...8/29/11 Lactose Free Mighty Shakes 3 times a day...8/31/11 Juven or House Equivalent to aid in wound healing...9/1/11 Vanilla Fortified Pudding to breakfast and supper as dessert...9/1/11 Choc (chocolate) Fortified Pudding to lunch as dessert...240 ml super shakes 3 times a day between meals duplicate order...9/29/11 Enlive Supplement i (one) container TID..." Nurses' notes dated 9/18/11 at 10:00 P.M. indicated "...Resident also accuses nurses of lying (sic) to him about his Super Shake for each meal - states the 'last nurse said she put it in refrigerator because she made it ahead of time & now no one can find it.'" A "Clinically at Risk Individual Monitoring Sheet" indicated: 9/7/11 "...Adm (admission) wt (weight) 117..." 9/15/11 "...Resident continues with weight instability...Wt 112...Appetite fair. Is a picky eater..." 9/21/11 "...Resident continues with weight instability. Nutritional interventions in place...Wt 109..." 9/29/11 "...Wt 108. Res will not drink 2 cal (calorie) or dairy products. Enlive (juice-like product) et is accepting super			

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	shakes made c (with) powdered milk..." A "Nutrition Assessment and Data Collection" form dated 9/1/11 signed by the dietitian indicated "...Will recommend to add fortified pudding at each meal as a dessert...Recommend 240 ml (milliliters) super shakes TID between meals...Will recommend to add fortified foods to diet order..." A "Medication Administration Record" dated September 2011 indicated "...Lactose Free Mighty Shakes 3 times a day (Nursing to make & give)..." Further review indicated: Documentation lacking to indicate the shake had been given 10 out of 90 times. The resident consumed 50% or less of the shake 37 out of 90 times. There was no documentation of the amount of shake consumed 18 out of 90 times. The resident refused the shake 2 times out of 90 times. Documentation was lacking related to the Juven or House Equivalent or the fortified pudding being given. A "Medication Administration Record" dated October 1-4, 2011 indicated "Lactose Free Mighty Shakes 3 times a			

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	day...Juven or House Equivalent to aid in wound healing..." Further review indicated documentation was lacking related to the Juven or House Equivalent being given. Review of a diet card dated 10/4/11 indicated "Super Shake made with water & powdered milk...between meals TID..." Documentation was lacking related to fortified pudding for desserts or fortified foods being provided. Meal intake sheets dated 9/4/11 through 10/3/11 indicated: Breakfast: The resident consumed 50% or less of his meal once with no documentation of a substitute being offered; there was no documentation of meal intake two times. Morning Snack: There was no documentation of a morning snack being offered 22 times. Lunch: The resident consumed 50% or less of his meal once with no documentation of a substitute being offered; there was no documentation of meal intake 9 times. Afternoon Snack: There was no documentation of an afternoon snack			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155782	A. BUILDING 00 B. WING	10/07/2011

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	being offered 24 times. Dinner: The resident consumed 50% or less of his meal 5 times with no documentation of a substitute being offered; there was no documentation of meal intake 5 times. H.S. (bedtime) Snack: There was no documentation of a bedtime snack being offered 26 times. A dietary note dated 9/22/11 indicated "...Wt 108# - down 9# since admission/7.7% wt loss in less than 30 days..." A CNA assignment sheet provided by the Administrator on 10/6/11 at 12:40 P.M. indicated "...super shakes with meals..." Interview on 10/4/11 at 2:25 P.M. with the Director of Nursing indicated there was no documentation of the Juven being given. She indicated she thought the supplements were documented on the meal intake sheets. Interview on 10/5/11 at 9:50 A.M. with the Dietary Manager indicated the resident should be getting super shakes three times a day between meals. She indicated to fortify foods, butter was added to vegetables and cereal. She indicated Super			

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	Shakes and Mighty Shakes were the same. "The company uses Super Shakes." She indicated the Enlive was provided by nursing and "nursing makes the shakes." Interview on 10/6/11 at 10:30 A.M. with the Registered Dietitian indicated the Mighty Shakes and Super Shakes were the same. She indicated fortified foods consisted of adding butter to oatmeal and mashed potatoes. If those foods were not on the menu, the fortified pudding was used as fortified foods. She indicated the Super Shakes were being used as Juven. She was unsure if the protein content was the same. Review on 10/5/11 at 1:10 P.M. of a facility policy and procedure dated 12/07, provided by the Director of Nursing, identified as current, and titled "High Risk Nutrition" indicated "...High Nutritional Risk Criteria:...Significant weight loss: 5% in 30 days, 7.5% in 90 days...Dx (diagnosis): malnutrition...protein calorie malnutrition...pressure sores...Two ounces (60cc [cubic centimeters]) Two Cal HN or equivalent high caloric product is to be given to predetermined residents daily by the nurse during each routine medication pass...The administration of prescribed supplement is tracked on the MAR (medication administration record) as is other medications...Nurses should record			

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	the amount consumed on the MAR..." 3.1-46(a)(1) 3.1-46(a)(2)			